Controlling Dutch Health Care

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The Dutch health care system presents a unique case. It strikingly displays a basic feature of the Dutch political system, which, in line with the work of Lijphart (1968) and the debate on neo-corporatism, can best be labelled 'consociational corporatism'. In other words, although health care is largely a public affair, for historical reasons the government controls it only in a rather limited sense (Schrijvers and Boot 1983).

In the years between 1813 (when the present Dutch state was founded) and 1945 the government abstained from entering the health sector, so private organizations conquered the field. When some form of state action became unavoidable, the government found itself confronted with well-established organizations which claimed jurisdiction over health care. When the state intervened it made no attempt to annex or incorporate them but rather tried to accommodate them. One intervention – and a decisive one – was the enactment of the medical statute in 1865 which provided uniform rules for professional training, a legal monopoly to academically trained physicians, severe penalties on unqualified practitioners, and a state inspection of health care (Cannegieter 1954). The statute was promoted by the Royal Dutch Society for the Advancement of Medicine (KNMG), itself founded for this purpose in 1849 (Festen 1974). KNMG still exists, and its two formally independent branches of specialists and general practitioners (GPs) are very influential.

Health care ranks prominently among the functions of the welfare state. In recent years its share of GNP has reached 10 percent, about three-quarters of which is public money. When economic crisis and a change in political climate required financial austerity, and therefore more control over health care, the latter proved to be no easy target. Control over health care involves dominance over three related areas of decisions: prices; medical consumption or volume (what facilities, where and how many); and the financial

system (who pays for what and in what way). The Dutch government has tried to structure its system along these lines, especially since 1974 when Parliament unanimously accepted an important government paper as the basis for future policy.

From 1945 to 1974

The war did great damage to the Dutch economy, and the first post-war election brought Christian and Social Democrats together in the cabinet. Their main target was to keep the costs of labour down in order to stimulate investment and economic growth. In the field of health care this was done in a number of ways. Hospital tariffs were under strict control as were all prices. Because of the scarcity of building materials, there was an annual budget for the (re)construction of hospitals, and sickness fund premiums were set at the lowest possible level. Charges by GPs were fixed, and central government gave as little subsidy to the Cross Societies (principal actors in public health care in the Netherlands) as was politically possible (Juffermans 1982). Macro-economically the government set the rules of the game very strictly, but it failed to plan the structure of the health system.

During the post-war years an important change took place in Dutch health care. The hospital changed from a place to nurse the sick into a therapeutic institution. Before the war, the bulk of health care was delivered by GPs. After it, hospitals and specialists took over. They did so for technical reasons, but also because after a German decree of 1941 the sickness funds paid for hospital care. This development caused an escalation of costs and a steady growth in the number of specialists.

Again private initiative took the lead by using public money. In 1950 only 37 of the 250 hospitals belonged to the state, whereas 112 were run by Roman Catholics, 43 by Protestants, and 58 by secular organizations. Between 1940 and 1960 the number of available hospital beds rose from 32,000 to 58,000 (Juffermans 1982). Existing hospitals were enlarged and new ones built at places where private organizations thought it proper, rather than where they might be most needed. Building continued until the annual budget was spent and sometimes beyond, with no regard for national priorities – largely because the central government provided none. After the budget was spent, the next applicant in principle had to wait until the following year. This kind of 'planning' created a very odd distribution of facilities, a fact which did not go unnoticed. In 1949 minister Joekes (Social Democrat) tried to get a planning bill enacted, but he failed because of strong opposition from the

confessional parties – mainly the Catholics – who had and have close ties with the well-established private organizations.

These organizations often competed with each other on the local level. Muntendam (1983), once the highest civil servant of the health department, has presented a nice example. A small town in a Protestant region had a well-functioning Roman Catholic hospital. It had been there for decades; it recruited both staff and patients from the region, and so many of both were Protestants. The mayors of the surrounding municipalities, however, supported by the local churches, wanted a wholly Protestant and therefore a second hospital. To everybody involved it was clear that, should they succeed, one hospital would necessarily fail. It proved impossible to convince the zealots that such a project would waste public money and, since Muntendam had no legal means to stop them, they had to be bought off. They got a Protestant hospital for the chronically ill. It prevented the bankruptcy of one institution, but did little to stimulate balanced development of the health system. Private, that is confessional, organizations had become powerful, not least because they had strong backing in Parliament where many MPs also held positions in the same organizations.

Public health care had become the virtual monopoly of the Cross Societies, but these had become dependent on government subsidies. The subsidy was based upon their battle against tuberculosis, although they performed many other tasks as well. Therefore they wanted it increased, something they obtained in 1952. The Cross Societies were pleased, of course, but not at all satisfied. They preferred a reliable flow of money from the government rather than an uncertain subsidy which was decided anew each year. A subsidy law would have suited their wishes, or alternatively money could have been provided through the social insurance system. Eventually the latter happened, but only in the late 1970s.

In 1949 the Sickness Fund Council was established as the official cabinet advisory board on all sickness fund matters including the premium rates. The premium is a percentage of the wage below an upper limit, of which half is paid by the employer and half by the employee. Since there was strict price control, the Social Economic Council (SER) also advised the minister on all prices. Often it advised a lower premium rate than did the Sickness Fund Council, because it wanted to keep the costs of labour down. The cabinet always followed the SER's advice (Juffermans 1982). The same policy was adopted with regard to the hospital tariffs; these were set as low as possible, thus forcing the hospitals (and the sickness funds) to use up their accumulated savings. This financial squeeze was only acceptable because price control was generally considered to be one

of the major pillars of reconstruction. It could not, however, last indefinitely.

In 1950, the scientific staff bureau of the Catholic Party produced a report on health care. The Christian Democrats objected to government interference in health care, although it did not really go far beyond price control. Yet the private initiative organizations wanted exclusive jurisdiction wherein government would provide only the money. The 1950 report has been the foundation for Dutch health politics for many years.

In 1956 the Central Health Council was set up. A typical example of the post-war cooperation of the private organizations and the government, it institutionalized consultation among the relevant interest groups, but made no attempt to restructure the health field. The Council advised the government – and its advice was almost always followed because of its strong backing by the confessional parties in Parliament, notwithstanding the fact that the organizations represented on the Council were often competing with each other at the local level. In Amsterdam, indeed, they competed not only with each other but also with local government institutions. One must bear in mind that the city ran several hospitals and was the first to establish a municipal health service (Verdoorn 1981).

In December 1958 there was a split in the coalition between Social Democrats and Catholics which had ruled the country since the end of the war. As the years of reconstruction were over, the Christian Democrats no longer needed the Socialists; the former took over, supported by the Liberals (in the Netherlands really conservatives, although less so in the first post-war years). That meant the end of the modest government control that existed at the time. The building and the tariffs of hospitals were 'liberated', so that if funds could be raised – and they easily could, for no health institution in the Netherlands ever went bankrupt – a local government automatically issued a building permit. Nothing could stop the construction of hospital facilities. Tariffs were negotiated between the sickness funds and the hospital organizations, the former always being the weaker party. Because the law guaranteed the insured medical care and not reimbursement of costs, the hospitals could always corner the sickness funds, for the latter had to implement the law.

Perpetual quarrels characterized the field until finally the minister made the two parties understand that if they would not develop stable forms of cooperation he would impose them. The parties responded, and in 1965 the Hospital Tariffs Act was enacted (de Wolff 1984). While it provided some control over tariffs, none of these dealt with medical consumption, which soon became the real

problem. As a consequence of the law, the Central Organization for Hospital Tariffs (COZ) was established, composed of the sickness funds and the hospital organizations which jointly set the tariffs. While the minister could overrule its decisions with regard to the national economic situation, he never did. COZ ruled supreme, although it was a *stichting*, that is a private law body. The years after 1965 witnessed a slow but steady growth of its tasks. Although functioning on a very weak legal basis, it determined more and more prices in health care (de Wolff 1984).

Yet the costs did not go down. In 1966 the Sickness Funds Insurance Act replaced the 1941 decree, but the new law merely codified the existing situation. In that same year the government produced a health care report which described the state of affairs but made no political choices. Nothing changed. Organizations in the field made use of every opportunity for growth, without any thoughts about a structure or a national plan.

In 1967 Parliament passed the General Special Sickness Expenses Act. It supplemented the Sickness Fund Insurance Act by covering heavy risks, like prolonged treatment, for the whole population. Implemented by the sickness funds and the commercial insurance companies, its premiums are paid by employers as a percentage of the wage. Since January 1980 most of the costs of the Cross Societies have also been met this way – partly to camouflage health costs, because subsidies appear on the budget whereas social insurance premiums do not. Yet the Dutch could not delude themselves indefinitely.

The first serious attempt to structure the field was made in 1971 through the Hospital Facilities Act. The law was only to come into force after the drafting of a national hospital plan, and it forbade the building of a hospital not included in the plan. The planning procedure, however, was made so complicated (because every organization in the field had to have a say in it) that no national plan was ever established. The law came into force in 1979, but the Act is still not very effective.

By 1974 it had become clear to everyone that the time had come to stop the growth of health care costs, be it only for macro-economic reasons. The then Secretary of State published a new Memorandum on the Structure of the Health Services, which Parliament approved unanimously. This Memorandum argued the need for more government intervention and promised to enlarge the influence of local and regional governments. It also emphasized primary care in order to reduce dependence on expensive hospitals, and recommended more preventive and non-residential care (that is more care by GPs and Cross Societies). The overall number of

hospital beds was to be reduced, the Hospital Tariffs Act was to be expanded to cover all health care prices, and a Health Services Act would replace the Hospital Facilities Act. This agenda was nothing less than a potential revolution. In the face of great difficulties, audacity may well have been needed. But making ambitious plans is one thing; implementing them is quite another.

The Mini-Revolution of 1974 and What Came of It

The developments leading to the Memorandum of 1974 were: a minimum of government interference; a complicated and differentiated financial system; an unbalanced growth leading to excessive emphasis on in-patient care and too little on ambulatory and preventive care; a lack of internal functional coherence; and the mushrooming of organizations (commonly called quangos) around the state bureaucracy which perform public tasks and dominate decision-making at the national level (Johnson 1979). Quangos are very important and are frequently used in Dutch health care. The most important ones for supply, cost, and the financing system are the Council of Hospital Facilities, the National Health Council, the Central Organization for Health Tariffs and the Sickness Fund Council. The National Health Council and the Council of Hospital Facilities are purely advisory bodies. Most members of these four quangos are representatives of interest groups or local authorities. In addition some members are appointed for their expertise, but civil servants in the Department of Health are excluded from membership. They may, however, attend as non-voting advisers (Hofland and Wilms 1984).

The remarkable nature of the 1974 Memorandum on the Structure of the Health Services cannot be overexaggerated. It announced no less than the restructuring of the health field through more government influence. More specifically it envisioned cost control through measures regarding price and financing, and enlarged controllability through matching supply and demand. These plans had to be executed along five lines: regionalization, echeloning, administrative organization, democratization, and legislation.

The Memorandum became the starting point for a wave of new laws and measures, which created new patterns of decisional power in Dutch health care. These can be grouped as mechanisms regarding control of supply, price and cost regulation, and regulation of financing (Rutten and Van der Werff 1982). The control of supply was directed to control of quantity, structure and quality of the available facilities. It came under two Acts: the Hospital Facilities Act and the Health Services Act.

Supply control

The most important ministerial powers or instruments in the Hospital Facilities Act concern the planning of hospital capacity, the issuing of building permits and the closure of hospitals. At the minister's request, the provinces must prepare regional hospital plans which specify the types of facilities (hospitals, nursing homes, and so on), the region(s) to be covered, and the financial limits. Each plan specifies the capacity and functions of facilities, states their optimal future level and indicates the way(s) to achieve it.

In order to guarantee the participation of the different parties concerned, the provinces must follow certain procedures which lead to a proposal drawn up by the provincial council. This is sent to the minister and to the Council of Hospital Facilities. The task of the latter quango is to advise the minister on the implementation of the Hospital Facilities Act. It consists of 25 members of whom the chairman is appointed by the government as a whole and the other members by the minister. Apart from two independent members the Council has representatives from organizations of hospitals, medical professions, financing bodies (sickness funds and private health insurance companies), municipalities, provinces, employers and employees. The seats are distributed as shown in Table 4.1. It is striking that the organizations of hospital facilities and medical professionals occupy nearly half the seats. Moreover, since medical professionals are amply represented in the organizations of financing bodies, the suppliers clearly dominate decision-making. The influence of employers and employees is minimal, while consumers occupy only one seat.

After the advice of the Council of Hospital Facilities, the minister finalizes the plan. If his version contains alterations of the proposal, the parties concerned may appeal to the government. Its approval will render the plan definitive and valid for a period of four years. No province has a free hand when drawing up its proposal. The ministerial directives serve as guidelines, and therefore as the basis for the final plan. These directives are manifold and highly detailed; they concern the structure of the plan (prospects, aims, and so on) and specific types of facilities.

The next important instrument is the permit. The law says that the construction of new hospitals and the extension, renovation, replacement, and alteration of existing ones are subject to ministerial approval.

If a particular hospital facility does not fit the official plan, the minister may decide to close down all or parts of it. The same may be done if it is no longer accredited by the Sickness Fund Insurance Act or the General Special Sickness Expenses Act. Before taking a

Table 4.1 *Distribution of seats in Dutch health care quangos (1987 figures)*

	Council of Hospital Facilities		National Health Council[1]		Central Organization for Health Tariffs		Sickness Fund Council	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Health care institutions and medical professionals	12	48	30	67	4	22	9	23
Financing bodies	5	20	4	9	4	22	9	23
Provinces and municipalities	3	12	4	9	–	–	–	–
Employers	1	4	2	4	2	11	7	18
Employees	1	4	2	4	2	11	7	18
Consumers	1	4	3	7	–	–	–	–
Independent experts	2	8	–	–	6	34	7	18
Total seats	25	100	45	100	18	100	39	100

[1]On the National Health Council the votes differ from the seats: see text.

decision of this kind the minister must consult the Council of Hospital Facilities and the provincial council involved, and the latter must consult the hospital and local authorities concerned.

By the end of 1988 the minister had ordered 102 proposals to be drawn up by the provincial councils. Actually 24 proposals have been drawn up and 17 plans have been finalized. This should not lead one to conclude that the provinces have done very little. Based on a section in the Act dealing with the closure of hospitals and prompted by the minister, most of the provinces have submitted proposals for a reduction of the number of hospital beds.

The Health Services Act seeks to control the supply of almost all health facilities in order to achieve decentralization, democratization and cohesion in the whole health services system. Its aim is very broad and reaches beyond mere volume control. At present, however, although passed by Parliament in 1982, the Health Services Act is not fully in force and probably never will be. As a result of a change in the political climate, people are less in favour of planning and more in favour of deregulation. Whether or not the Act will be withdrawn is uncertain. The most important instruments of the Act are planning and accreditation, establishment and size of practice, and prescription of quality standards.

Under the Health Services Act planning would also be done by municipalities. In principle they would be responsible for planning primary care facilities through a procedure much like that under the Hospital Facilities Act. The provincial plan would need governmental approval, and the municipal one had to be approved of by the provincial executives. The National Health Council advises the minister on the Health Services Act. Advice on the Health Services Act is not the only task of the National Health Council, for it also advises on structure, implementation, quality, legislation, efficiency, and indeed on all matters concerning health care.

In addition, the Council attempts to promote cooperation among the authorities and private organizations in the field. It has 45 members, with its seats distributed as shown in Table 4.1. However, the number of votes differs from the number of seats. The votes of the representatives of the financing bodies, provinces, municipalities, employers, employees and consumers count double so, taken together, their votes match those of the suppliers of health care. Nevertheless, since medical professionals are also represented on the financing bodies, the suppliers of health care have the greatest influence on the National Health Council.

Health care services offered by independent medical professionals are not covered by the planning procedure of the Health Services Act. Volume control in this area is achieved by separate regulations

in the law concerning location and size of practice. The law can dictate that a specific category of (medical) professionals is not allowed to set up practice in (part of) the country without a permit. So far this only applies to GPs. At present this regulation is one of the few parts of the law which are in force.

Price and cost control

The second line of regulatory mechanisms concerns price and cost control, based particularly on the Health Tariffs Act, various budgetary measures, and the Financial Survey of Health Care. The Health Tariffs Act was implemented in 1982 and replaces the Hospital Tariffs Act of 1965 which only allowed price control of in-patient health care. The more extensive Health Tariffs Act applies to the entire field of health care. The act rules that all tariffs and fees need the approval of the Central Organization for Health Tariffs. Tariffs are fixed according to the following procedure. In principle the organizations of medical professionals and institutions first meet the organizations of financing bodies to discuss tariffs. If they agree, the tariff will be submitted for approval to the Central Organization. If they cannot reach an agreement, the Central Organization may officially or by request establish the tariff. If they wish, the parties concerned may express their views.

The Central Organization then examines the tariff on the basis of directives as to the size, structure and calculation of the tariff. The directives are, as it were, the limits within which the parties are free to bargain. They are established by the Central Organization itself, independently or on ministerial guidelines from the Minister of Health and/or the Minister of Economic Affairs. These directives require ratification by the minister. Decisions on tariffs taken by the Central Organization may be suspended or nullified by government at a later stage on grounds of their being against the law or not in the public interest. In addition, anyone whose interest is harmed by a decision on tariffs may appeal to the Professional Appeals Board.

The Central Organization for Health Tariffs plays an important role in the process of price regulation. It not only approves tariffs, but also develops directives, and advises the government on all subjects concerning price development in health care. The Central Organization consists of eighteen members of whom six are appointed by the government, four by the minister after consultation with the organizations of the health care institutions and medical professionals, another four after consultation with the organizations of financing bodies, and the final four after consultation with the organizations of employers and employees (Table 4.1).

The law requires that the members of the Central Organization must not be professionally involved with the organizations of health institutions, professionals, and financing bodies which participate in the discussions on tariffs. They can be members of these organizations, though nomination by the various interest organizations is not binding; members of the Central Organization are appointed after consultation.

There are six subcommittees for various categories of health care institutions which come under the Central Organization. The members of these committees are representatives of the organizations of health care institutions, medical professionals, and financing bodies. The seats of the first two together equal those of the third. Members of the committees need not be members of the Central Organization itself; they are nominated by the afore-mentioned organizations and appointed by the Central Organization. The only task of these committees is to advise on directives. They are not involved in the establishment of tariffs. Although the members of the Central Organization do not directly represent the interest organizations which recommended them for membership to the minister, they belong to them and are likely to consider the interests of their organizations. They are thus interested parties when decisions are taken.

Significantly, consumer organizations again are not represented. However, the suppliers of health care have considerably fewer seats (proportionally) than on other bodies, and independent experts play a more important role. The influence of suppliers and financing bodies is limited, and that of consumers nil. On the other hand the committees, whose role in the development of directives is important, allow the suppliers and financing bodies to have much greater influence. Here, they control half of the total number of seats.

In 1983, hospitals had to abandon the tariff system in favour of the system of budget financing because hospital costs account for an enormous share of total health care costs. From 1984 budget financing has also been applied to all other in-patient health services. The term 'budget financing' stands for a system by which institutions receive a budget in advance from which to finance the health care services. It is important that costs do not exceed the limits, in order not to jeopardize future budgets. Budgets are fixed by the Central Organization for Health Tariffs after consultation with health institutions and financing bodies. However, since the system does not cover the services of medical specialists, budget financing cannot achieve total control of in-patient health care costs.

Finally, the annual *Financial Survey of Health Care* (published by

the government since 1977) not only contains an analysis of costs made in the entire health care system, but also gives a forecast of costs for three years ahead. This framework functions as a target for the government and an indicator for the social insurance institutions.

Finance control

Control of financing (the third regulatory mechanism) is based primarily on the social insurance schemes of the Sickness Fund Insurance Act and the General Special Sickness Expenses Act. The Sickness Fund Insurance Act gives those insured (61 percent of the total population) the right to medical care, such as basic and specialist treatment, obstetric, hospital and psychiatric treatment, and so on. The nature, content and amount of medical care is described in a decree which accompanies the Act, the so-called coverage decree. Implementation of the Act rests with the sickness funds, which stipulate contracts with organizations and individuals providing health care. Those insured with one of the 52 sickness funds have to approach an institution or (medical) professional who has a contract with that particular sickness fund. Negotiations about the contents of contracts take place between the sickness funds and the organizations of health care institutions and professionals. When agreement has been reached, the contract (except the part dealing with the tariffs) is submitted to the Sickness Fund Council for approval. In addition, the Sickness Fund Council advises the government and the Ministers of Health and Social Affairs on all matters concerning the Sickness Fund Insurance Act and the General Special Sickness Expenses Act.

The Sickness Fund Council has 39 members, appointed by the organizations of employers, employees, sickness funds, private health insurance companies, health care institutions and medical professionals. In addition a number of independent experts are appointed by the minister. The distribution of the seats is shown in Table 4.1.

The minister may advise the Council on the performance of its task. Decisions taken by the Council, if incompatible with the law or the public interest, may be suspended or nullified by government. Interested parties may appeal to government against a number of Council decisions (such as those on payments to executive bodies).

The distribution of representatives in the Council indicates that employers and employees have more influence than they have in other quangos. The number of their seats almost equals that of the other interest groups; we may therefore conclude that there is a fair representation of interests. The only group not represented is that of consumer organizations.

As the General Special Sickness Expenses Act (1967) deals with the insurance of all residents of the Netherlands against exceptional medical expenses, it applies to facilities and services such as nursing and treatment in hospitals and psychiatric and mental institutions for longer than 365 days. Implementation of the Act rests with the sickness funds, private health insurance companies and executive bodies of civil servants' health insurance schemes. The Sickness Fund Insurance Act and the General Special Sickness Expenses Act state that every institution which offers health care and requires financing from the funds of these Acts must have ministerial accreditation. The minister grants accreditation mainly on the basis of quality criteria. Prior to taking a decision on accreditation the minister will ask the advice of the Sickness Fund Council.

Discussion and Conclusion

This chapter has described the Dutch health services system from 1945 to the present. This period has been divided into two – before and after 1974. For many years, until the end of World War II, health care ranked low among the priorities of the Dutch government. Government abstained as much as it could, leaving the field to societal initiative. Many organizations were established, and they made full use of the growth possibilities of the welfare state between 1945 and 1974. In that period government restricted itself to safeguarding these organizations and their income. But this situation led to an unbalanced expansion and an explosion of costs. The Dutch health care system was characterized by a minimum of government interference, a complex financial system, a lack of internal coherence, and many predominantly para-governmental organizations. Parliamentary acceptance of the ministerial Memorandum on the Structure of Health Care in 1974 marks the end of this period, after which a phase of attempted governmental control began.

How successful were those attempts? It is obvious that government interference increased, while the autonomy of health care facilities and professionals decreased. A recent study (Honigh 1985) points out that government does make use of its new powers, especially where the building of new hospitals is concerned. But the Council of Hospital Facilities quango (with its strong representation from hospital facilities and professionals) seems to be very influential because of its leading role in communications about these measures. Also most advice from the Council was accepted by the ministry and seemed to outweigh the provincial advice. Hitherto the role of the provinces and municipalities in health policy-making has been limited. Decentralization progresses slowly and is hindered by

arguments of deregulation coming from central government. This problem will not be solved as long as it remains unclear which conditions will facilitate the optimal relation between decentralization and deregulation.

Another problem is the strong tendency towards bureaucratization and slow decision-making, which hinder or even obstruct the desired effects of cost control and the better manageability of the total health care system. It is necessary and possible to stop this tendency, but powerful participants will perceive such striving to be against their own interests. Total costs of health care are still rising, although at a slower rate than before 1974. It is not clear, however, whether this reduced rate of growth is caused by the new health policy or by the general retrenchment policy which developed in response to the economic recession.

Real cost control cannot be achieved as long as the nature of the financial system itself remains unchanged and as long as a gap remains between the planning and financing. Government only indirectly influences prices by the establishment of prior limits on tariffs. But the financial system itself, which contains many incentives to spend, has not changed. Doctors can compensate for lower tariffs by consulting more often, and indeed an increase in consultations has occurred during the last few years. The doctor's pencil is still the most expensive instrument in the whole health care system.

Moreover, the relations between planning, costs and financing are unclear. Whereas the planning decisions, taken under the Hospital Facilities Act, do determine hospital capacities, they fail to state the medical production to be obtained and the costs involved. Other problems arise because of the fact that the planning system must be decentralized, while the financing system is centralized. The trend to unbalanced growth is still perceivable, but seems to be less strong than before.

Furthermore, although the expansion of the in-patient sector has clearly slowed, only a limited reduction of in-patient capacity (number of beds) has occurred. The Netherlands remain characterized by a very strong in-patient and a very weak out-patient sector, despite all pronouncements of central government concerning the need to strengthen the out-patient sector. These shortcomings, namely, growing government interference, slow decision-making, the misfit between planning and financing and a trend towards unbalanced growth, have been discussed extensively, leading to the conclusion that cost and supply control were not being successfully implemented. As a reaction to that, the government appointed an

advisory committee on the structure and financing of health care, presided over by a well-known captain of industry. The committee's report (Commissie Structuur en Financiering Gezondheidszorg 1987) was based on two ideas. Firstly, the insurance system had to be simplified. The second idea was less government and more market. As a consequence the Health Services Act has had to be withdrawn. In its latest reaction to the committee's report (Verandering verzekerd 1988) the government agreed on its essentials. Nevertheless it is still uncertain how the new system is going to be implemented. The original goals of the Memorandum of 1974 have not been reached, as is shown above. But this does not mean that there has been no effect at all. For instance, the legislation has brought about a number of changes in the quango structure. In 1982 the National Health Council succeeded the Central Health Council (instituted 1956) and the Central Organization for Health Tariffs replaced the Central Organization for Hospital Tariffs (instituted 1965).

Table 4.2 *Average percentages of seats for interest groups on Dutch health care quangos*

	Before 1982	After 1982
Health care institutions and medical professionals	39	39
Financing bodies	24	19
Employers	5	9
Employees	5	9
Consumers	0	4

Table 4.2 shows the average percentages of seats for each interest group before and after 1982. These comparative figures reveal a slight decline in the share allotted to financing bodies, and a small increase in the share allotted to organizations of employers, employees and consumers. This change is the result of a reduction in the number of seats occupied by the financing bodies in the Central Organization for Health Tariffs and the Council of Hospital Facilities. At the same time the financing bodies have strengthened their foothold in the National Health Council. Organizations of employers and employees, which were not represented in the Central Health Council and the Central Organization for Hospital Tariffs, do have seats in their successors. Opportunities for influence are now a little more evenly divided among various

interest groups. But there remains a heavy bias toward the organizations of health care institutions and medical professionals, with a corresponding disadvantage for the organizations of employers, employees and consumers. The financing bodies are somewhere in the middle.

The growth of the government's powers since 1974 certainly had an impact on the system, but did not cure all its ailments. In fact, some grew worse. One important reason for that is the fact that the use of these powers is restricted by the quangos, which all retain important tasks in the preparation and implementation of health care policy. Hence health policy-making in the Netherlands is controlled not only by the government but also by a number of interest groups which influence decision-making in this field. The concept of 'consociational corporatism' accurately labels this phenomenon. The dominance of the medical interest group can be explained as a consequence of the long existence (over 100 years) of a very strong medical professional organization, which maintains important lines of formal and informal influence over health policy-making. It is not at all certain that the newly proposed market-minded and deregulatory policy will bring about the changes needed. In 1988 everything seems to be in flux. It may well be that in ten years' time we will perceive that the 1987 report, like the Memorandum of 1974, marked the dawn of a new era. That may be, or it may not. As we remarked before, making plans is one thing, getting them implemented is quite another.

Note

Since no authorized English translation of the names of many health-related laws and organizations exists, the following list clarifies Dutch usage:

Algemene Wet Bijzondere Ziektekosten (AWBZ): General Special Sickness Expenses Act
Centraal Orgaan Tarieven Gezondheidszorg (COTG): Central Organization for Health Tariffs
Centraal Orgaan Ziekenhuistarieven (COZ): Central Organization for Hospital Tariffs
Centrale Raad voor de Volksgezondheid: Central Health Council
College voor Ziekenhuisvoorzieningen: Council of Hospital Facilities
Nationale Raad voor de Volksgezondheid: National Health Council
Structuurnota Gezondheidszorg: Memorandum on the Structure of the Health Services
Wet Tarieven Gezondheidszorg (WTG): Health Tariffs Act

Wet Voorzieningen Gezondheidszorg (WVG): Health Services Act
Wet Ziekenhuistarieven (WZT): Hospital Tariffs Act
Wet Ziekenhuisvoorzieningen (WZV): Hospital Facilities Act
Ziekenfondsraad: Sickness Fund Council
Ziekenfondswet (ZFW): Sickness Fund Insurance Act